



Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #:	M4-10-4351-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name and Box #: TPS JOINT SELF INS FUNDS Box #: 42	Date of Injury:	
	Employer Name:	
	Insurance Carrier #:	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Also as of today they are no longer paying for his seizure medications – this is no longer funny. This has now become life or death."

Principle Documentation:

1. DWC 60 package
2. Receipts
3. Total Amount Sought \$517.07

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Respondent seeks a finding that Requestor is due no further funds as a result of its request for reimbursement. The two disputes related to medications and DME have been referred to an IRO. The mileage reimbursement request is not proper in this venue and is otherwise not available in this matter. Respondent respectfully requests consideration of its position stated herein and seeks continued denial of the additional requested amount of its claimed reimbursement. In alternative, this matter should be dismissed as MDR does not have jurisdiction.

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
01/31/10 – 04/01/10	Unnecessary Medical	Out-of-Pocket expense – Prescriptions	\$517.07	\$0.00
Total Due:				\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.270 sets out the procedures for injured employees to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.270 sets out the procedures for injured employees to submit workers' compensation medical bills for reimbursement.
3. 28 Tex. Admin. Code §133.270 sets out the fee guidelines for the reimbursement of the out-of-pocket expenses incurred by the injured employee for their workers' compensation injury.

Issues

1. Did the requestor submit the request for payment of out-of-pocket expenses in accordance with 28 Tex. Admin. Code §133.307?
2. Did the requestor file for mileage reimbursement to the proper venue?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor's spouse was contacted in regards to the request for medical fee dispute resolution. The Division was informed by the spouse that the respondent had denied payment for the out of pocket expenses as not medically necessary. The Division informed the claimant's spouse that these charges would have to be reviewed by an Independent Review Organization (IRO) and that an LHL-009 would have to be completed and sent to the insurance carrier's preauthorization department. According to the position statement received by the respondent the claimant has filed the proper form for review by an IRO. Therefore, in accordance with 133.307(e)(3)(I) the request for medical fee dispute resolution was not submitted in compliance with the provisions of the Labor Code and this chapter.
2. The requestor also noted on the table of disputed services that the insurance carrier owed mileage from January 2004. When speaking with the claimant's spouse, she was informed that the proper venue for obtaining reimbursement for mileage was the claimant's workers compensation field office. Therefore, in accordance with 133.307(e)(3)(I) the request for medical fee dispute resolution was not submitted in compliance with the provisions of the Labor Code and this chapter.
3. **Conclusion** For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
Texas Administrative Code Sec. §133.307

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to \$0.00 reimbursement.

August 18, 2010

Authorized Signature

Auditor III
Medical Fee Dispute Resolution

Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.